The Policy Environment Score

Measuring the Degree to Which the Policy Environment in Jamaica Supports Effective Policies and Programs for Adolescent Reproductive Health: 2004 Round

by
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November 30, 2004

This report is made possible through support provided by US Agency for International Development Jamaica Mission under Contract No. 532-C-00-00-00003-00. The opinions expressed do not necessarily reflect the views of US Agency for International Development.

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Abbreviations

ARH	Adolescent reproductive health
ECP	Emergency contraceptive pills
HFLE	Health and family life education
IEC	Information, education, and communication
MOE	Ministry of Education
MOH	Ministry of Health
NFPB	National Family Planning Board
NGO	Nongovernmental organization
PAS	Political-administrative system
PES	Policy environment score
PIOJ	Planning Institute of Jamaica
STD	Sexually transmitted disease
STI	Sexually transmitted infection

I. Introduction

Purpose

The Policy Environment Score (PES) is intended to measure the degree to which the policy environment in a particular country supports the reproductive health of the population, with particular focus on access to high-quality family planning and reproductive health services. It is designed to reflect both the level of support and changes that take place during one to three years as a result of policy activities. This score has two major purposes:

1. To indicate the current status of the policy environment including the strongest and weakest elements.
2. To evaluate the impact of policy activities and limitations.

Definitions

For our purposes, we define policy to be actions, customs, laws, or regulations by governments or other social/civic groups that directly or indirectly and explicitly or implicitly affect fertility, family planning, or reproductive health. This extends earlier definitions (Maguire, 1990) to recognize that policies can be direct or indirect and explicit or implicit. This definition excludes population policies affecting overall mortality, migration, and spatial distribution but includes health policies affecting all aspects of reproductive health.

II. Conceptual Framework

Local governments and international donors have a history of supporting activities designed to improve health in the developing world. Among the many lessons learned from this experience is that a supportive policy environment is a major factor in the success of most, but not all, national programs (Clinton, 1979; Freedman, 1987; Merrick, 1989). USAID and other donors have supported population and health policy activities for the past 25 years. There now exists a large and diverse literature base concerning the components of the policy environment and how the various elements interact to affect services and outcomes. In 1994, the USAID-funded EVALUATION Project addressed the issue for family planning activities with a working group on population policy indicators. A considerable amount of background research was done in preparation for the working group. Much of the following discussion expands on the report of the working group (Knowles and Stover; 1995).

The policy environment is defined as the factors affecting program performance that are beyond the complete control of national program managers. In addition to political support and other expressions of national policy (e.g., a formal national policy), the policy environment includes those aspects of operational policy that involve decisions at a higher level than the program (e.g., the program's organizational structure, its legal/regulatory environment, the resources made available to it, and its use of provider and acceptor payments and fees).

Figure 1 presents a conceptual framework for the policy environment. The framework is organized according to the standard Input-Process-Output-Outcome schema and depicts policy activities of a single period as part of a continuous circular loop. The policy environment is the output of the policy process. It directly affects the various functional areas of programs (e.g., information, education, and communication (IEC); training; commodities and logistics; management; institutionalization; self-sufficiency; and demand for services).

Inputs to the policy planning and development processes include

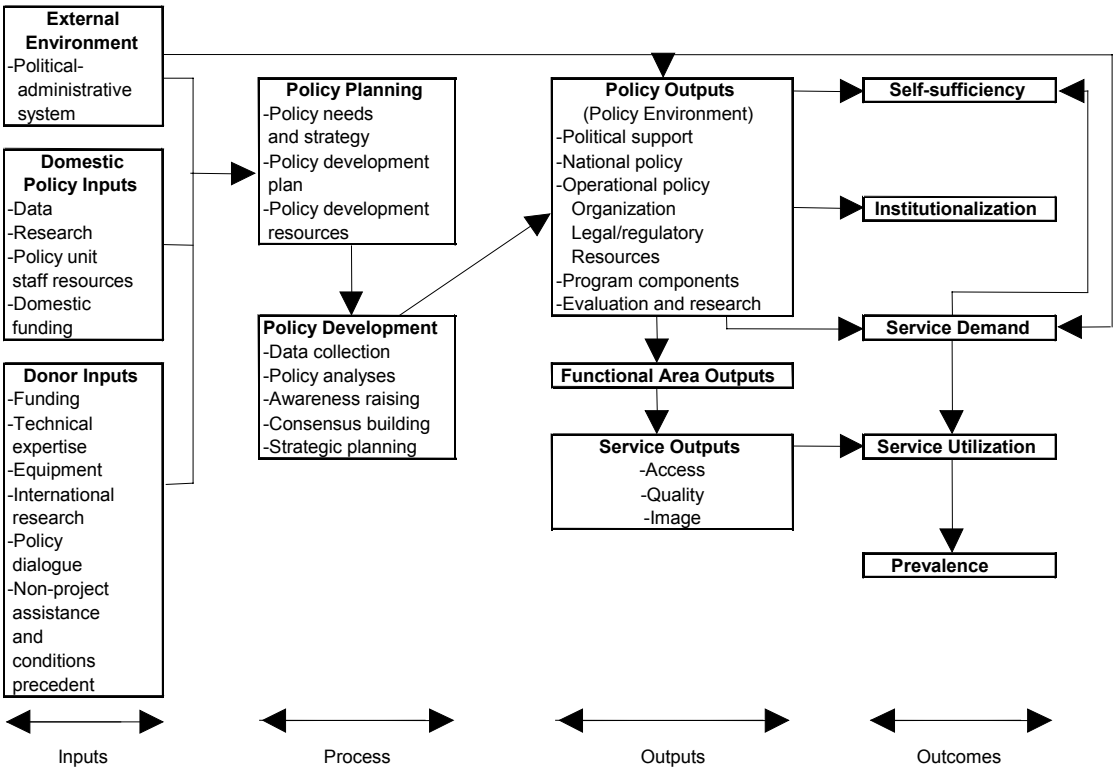
- The external environment;
- Domestic policy inputs; and
- Donor inputs.

The external environment includes a country's political–administrative system (PAS), its socioeconomic characteristics, and its sociocultural environment. Domestic policy inputs include available data, existing research, staff resources of policy units, equipment (e.g., computers and audio-visual equipment), and domestic funding. Domestic inputs are enhanced over time to the extent that the institutionalization of policy development capabilities is an effect of policy work. (Figure 1, as a single-period schema, does not explicitly show the feedback effect from institutionalization in one period to levels of domestic policy inputs in the following period; however, this should be considered as part of the conceptual framework.) Donor inputs to policy development include specialized technical expertise, equipment, funding, international research, policy dialogue, non-project assistance, and conditions precedent to loans and grants.

The policy environment is modified over time through the planned implementation of policy activities (i.e., the process of policy planning and policy development). Policy planning is based on an assessment of the current policy environment in relation to program needs and of the inputs available for further policy development. Many policy development activities, or policy interventions, are designed to strengthen political support and/or to develop an effective national policy in support of reproductive

health programs. As support for programs grows at the national level, policy interventions are usually directed to strengthening the operational policy environment.

Figure 1. Conceptual Framework for the Evaluation of the Policy Environment



As shown in Figure 1, the external environment (directly), other policy inputs (indirectly), and the process of policy development determine a national program's policy environment. The dimensions of the program policy environment, which is the output of the policy development process, include the following:

- Political support
- National policy
- Operational policy
- Program components
- Evaluation and research

Political support at national, regional, and local levels plays a central role in a program's policy environment since it is an important determinant of the other dimensions of the policy environment. Political support can be both explicit and implicit. Statements made by high-level government officials and other leaders in support of reproductive health programs may indicate explicit support. Implicit political support is most often gauged by what the government actually does in the areas of national and operational policies and programs.

National policy includes both formal statements of policy (e.g., national policies and national development plans) and tax and other material incentives designed to affect decisions.

Operational policy consists of three subdimensions that are directly related to the operation of national programs:

- *Organizational structure and processes*: a program's status within the government's administrative structure and its capacity to mobilize the resources of other public and private institutions.

- *Legal/regulatory environment*: taxes and other restrictions that affect the supply of commodities, particularly from the private sector, and medical barriers to service delivery and information activities.

- *Provision of resources*: financial, material, and human resources needed by programs.

Program components are intended to explicitly capture whether specific program components are included in the program by formal policy. This could be included under national policy; however, it seems better to separate it from the broader national policies.

Evaluation and research is intended to capture whether these activities are present to support the process of policy formulation.

According to Figure 1, improvements in the program policy environment should lead to stronger service delivery (access, quality, and image), increased service use and behavior change, and enhanced institutionalization and self-sufficiency of programs. As noted above, institutionalization also affects levels of domestic policy inputs in the following period (a feedback loop). On the supply side, therefore, the policy environment contributes directly to both improved service delivery in the short run and enhanced program sustainability in the long run. On the demand side, both political support and national policy dimensions of the program policy environment (e.g., statements of leaders) affect demand for services.

This framework has been used to develop the major categories for the PES shown below.

Composition of the Policy Environment Score

All of the items in the conceptual framework could be included in the PES. However, we have chosen to limit the PES to those items that both define the policy environment and can be influenced by policy activities.

Items in the conceptual framework (Figure 1) listed under *External Environment* and *Donor Inputs* are assumed to be outside the potential influence of policy activities. Therefore, they are not included in the PES. It could be argued that they should be included since they do help define the environment for policy; however, since they cannot be affected by policy activities, their inclusion would reduce the usefulness of the score as an evaluation device.

Items under *Domestic Policy Inputs, Policy Planning,* and *Policy Development* are the inputs and processes used by policy activities to affect the environment. Therefore, they do not belong in a measure of the environment itself.

Items under *Policy Outputs* represent the elements of the policy environment that policy activities attempt to influence. These items define the categories of the PES:

- Political support

- National policy (or policy formulation)
- Operational policy
  - Organization and structure
  - Resources
  - Legal/regulatory
- Program components
- Evaluation and research

A number of specific items could be included under each of these headings. Selection of items included in the PES is intended to capture the most important indicators in each category.

III. Implementation of the Policy Environment Score in Jamaica

In Jamaica, the PES has been used to assess four separate reproductive health programs, including:

- *Family planning:* programs to provide high-quality family planning services to men and women who wish to plan their families.
- *Safe pregnancy:* programs to ensure that pregnancies are as safe as possible by providing good prenatal, postnatal and delivery care and by identifying and treating high-risk pregnancies.
- *STDs/AIDS:* programs to control the spread of sexually transmitted diseases (STDs), including HIV (the virus that causes AIDS), and to ensure the human rights of individuals affected by HIV/AIDS.
- *Adolescents Reproductive Health (ARH):* programs to enhance the reproductive health of adolescents through education and services.

Two rounds of the original PES have been fielded in Jamaica, first in 1999 and second in 2000. These rounds were conducted by the POLICY Project on behalf of USAID/Kingston (McClure et al., 2000; Strachan et al., 2001). Those rounds of the PES included four components of reproductive health, namely family planning, safe pregnancy, STDs/AIDS, and 'adolescents'.

In 2002 an expanded version of the PES was conducted jointly by the Jamaica Adolescent Reproductive Project, (Youth.now) and the POLICY Project, focusing exclusively on adolescents. Called the *Expanded* ARH PES, the 2002 round included the same questions regarding adolescent reproductive health (ARH) that were used in 2000 and 1999 (hereafter referred to as the "original" ARH PES) and also included a number of additional questions to more accurately reflect the policy environment for ARH in Jamaica in 2002, given policy and program activities undertaken over the past few years (hereafter referred to as the "expanded" ARH PES). This version of the PES therefore became the baseline for the ARH PES.

The Expanded ARH PES was again conducted in 2004. Like the 2002 Expanded ARH PES, the 2004 version also included the seven components of *political support, policy formulation, organization and structure, legal and regulatory, program resources,* and *evaluation and research.*

To measure change in the policy environment, respondents were asked to rate each item twice—once to reflect the current status in 2004, and once to indicate the status one year earlier - 2003. The complete Expanded ARH PES instrument is in Appendix B.

Sampling and Data Collection

A total of 38 respondents participated in the survey between June and July 2004, out of 60 contacted. Appendix A lists the respondents.

Respondents were chosen because of their knowledge about the adolescent reproductive health program and because they represent various viewpoints. Thus, respondents included those working within the public sector programs as well as those outside the program. Respondents included staff of the Ministry of Health (MOH), the National Family Planning Board (NFPB), nongovernmental organizations (NGOs), the University Hospital of the West Indies, the private sector, and international donors. There was some overlap in respondents in the 1999 baseline survey, the 2000 follow-up survey, the 2002 baseline on ARH and this survey.

In inviting them to participate, respondents were contacted by telephone, email, or in person. Forms were delivered, emailed or faxed to respondents in the Kingston region and faxed or emailed to those in rural

areas. Follow-up contacts were made to ensure that all respondents completed and returned the questionnaires on time. Some participants failed to complete the questionnaires following several reminders, and some referred them to colleagues who were already respondents. In some cases, some questionnaires had to be resubmitted as respondents had either mislaid them or had not received them. The entire process took place from May 5th and June 30th.

Scoring

All of the items in the PES are scored on a 0–4 scale. The definition of the scale varies somewhat depending on the category (as shown in the Expanded ARH PES questionnaire in Appendix B) in order to provide clear guidance to the scorer. For analysis of the "original" ARH PES (that compares to the 1999 and 2000 rounds), only questions in regular type were included. For analysis of the "expanded" ARH PES, all of the questions (the additional questions are indicated by italics on the questionnaire), with the exceptions of I.1, I.4, I.11, II.1, and II.8 were included. Questions I.1, I.4, I.8, and II.1 were excluded from the analysis because the same information was asked in more detail in other questions, and question II.8 was excluded because it was inadvertently redundant with question II.7.

Several respondents did not answer all of the questions for components about which they were not familiar. Therefore, individual and component scores reflect on the number of responses per question. Overall scores reflect the responses of people who answered a majority of the questions. If one respondent did not answer any of the questions in one category (e.g. *political support*), the overall score did not include this person's responses.

The first step in calculating the total score is to sum the individual item scores within a category. These subtotals are converted to averages by dividing by the number of items that were scored. (This procedure computes an average score per item scored; thus, items that were not scored by the respondent do not reduce the score.) These averages are converted into percentages by dividing by the maximum possible score for each category. This approach standardizes the categories so that the number of individual items within a category does not affect its contribution to the total score.

The sum of all the weighted category scores is the total ARH PES. The final score is adjusted to range from 0–100, with 100 indicating a perfect policy environment.

Results

The results section of this report presents and discusses results of the 2004 Expanded ARH PES in Jamaica. As indicated, data are available on the policy environment for 2004 and for the previous year – 2003.

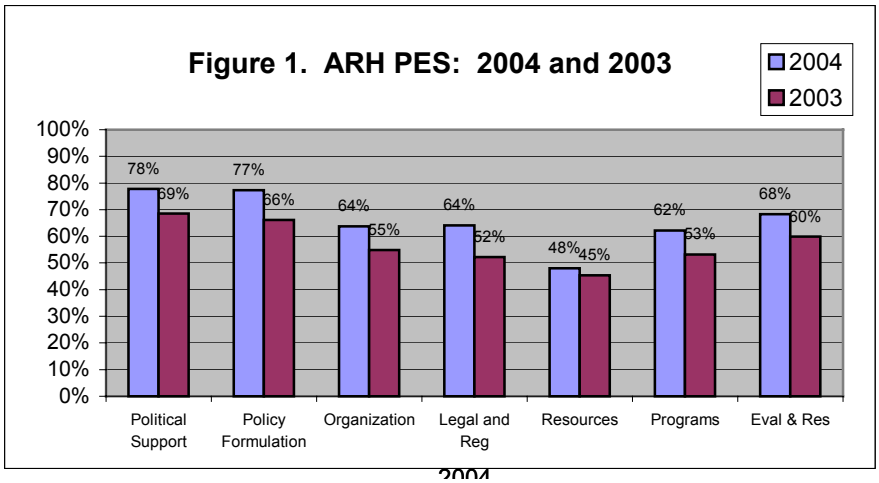
Scores for each component of the Expanded ARH PES are shown in Table 1 (Figure 1 shows the same information in graphic form). The total Expanded ARH PES increased from 57.2 percent of the maximum of 100 percent in 2003 to 65.9 percent in 2004.

Table 1. Comparison of Expanded[1] Adolescent Reproductive Health (ARH) Policy Environment Scores (PES) by Program

Components: 2004/2003			
Component	**2004**	**2003**	**Change (in % points)**
All components	**65.9**	**57.2**	**8.8**
Political Support	78	69	9.0
Policy Formulation	77	66	11.0
Organization	64	55	9.0
Legal and regulatory	64	52	12.0
Resources	48	45	3.0
Programs	62	53	9.0
Evaluation and research	68	60	8.0

Note: Values can range from 0 – 100.

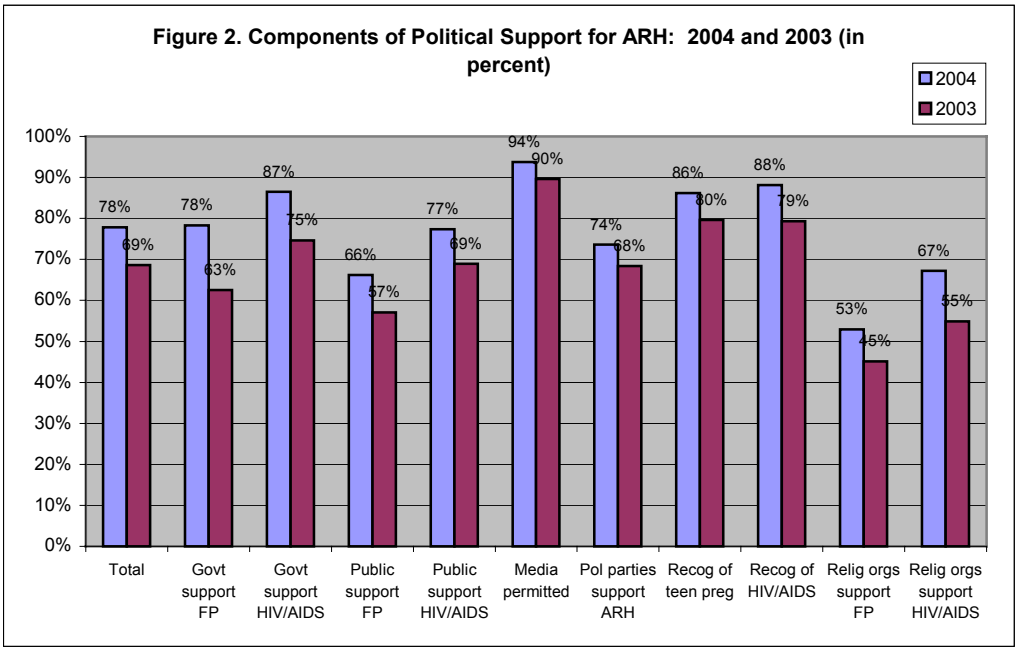
[1]The Expanded ARH PES includes original questions from the 1999 and 2000 rounds of the PES and additional questions added on ARH in 2002



The ARH PES was rated 8.8 percentage points higher for 2004 than for 2003, indicating that respondents see a small positive trend in the policy environment for ARH in Jamaica. Scores increased in all components of the PES. In 2004, two components – political support and policy formulation – achieved a score above 70 percent (78 and 77 percent respectively). These categories also showed significant improvement, with an increase of 9 and 11 percentage point respectively between 2003 and 2004. The other six components received scores between a low of 48 percent (the resources component) to a high of 68 percent (evaluation and research). Although that was inferred in the scores for all components, these scores changed at different rates, from a 12 percentage point jump in the legal and regulatory component (the greatest change) to a 3 percentage point rise in the resources component (the smallest change).

Political Support (69% in 2003 and 78% in 2004)

Political support was the highest ranked component in the Expanded ARH PES at 78 percent. Scores for the components of the political support are shown in Figure 2. Respondents noted significant improvement over the years, with a 9-percentage point increase.

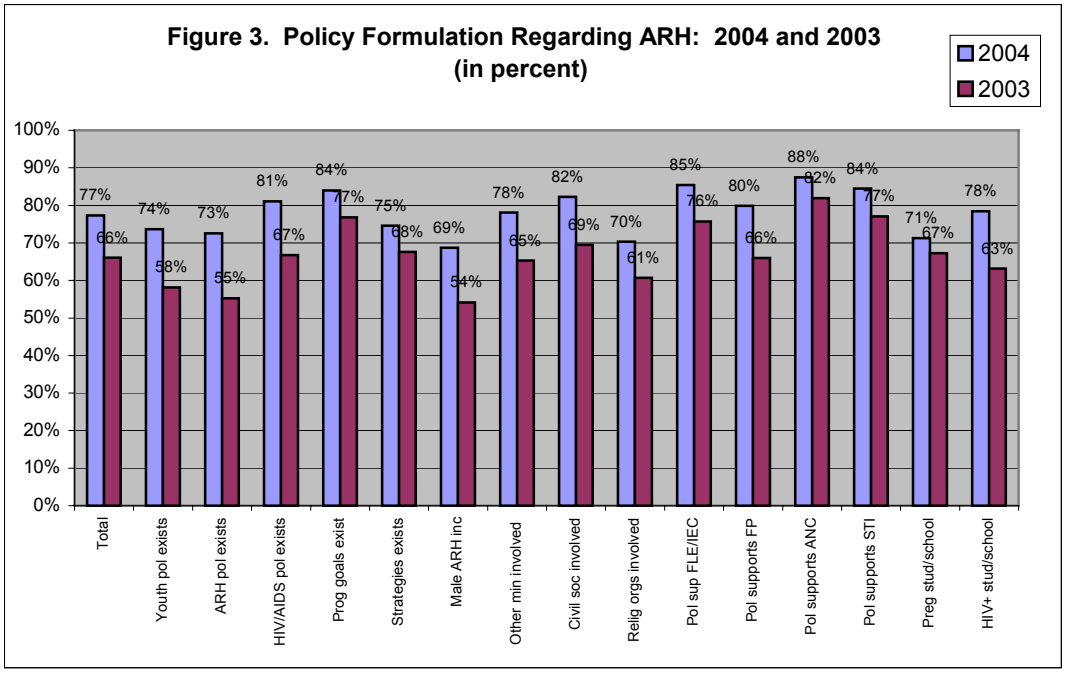


Note: The complete list of items in each component is found in the ARH PES questionnaire in Appendix B.

The use of the media to support RH and HIV/AIDS reflects the highest score (94 %). The recognition of HIV/AIDS as a problem by top planning bureaus (88%), recognition of teen pregnancy as a problem (86%) and high-level national/government support for effective policies and programs for prevention of HIV/AIDS (87%) also received high scores. Respondents did not perceive that religious organizations offer much support for family planning (53%) although they are more supportive of HIV/AIDS programs for youth (67%).

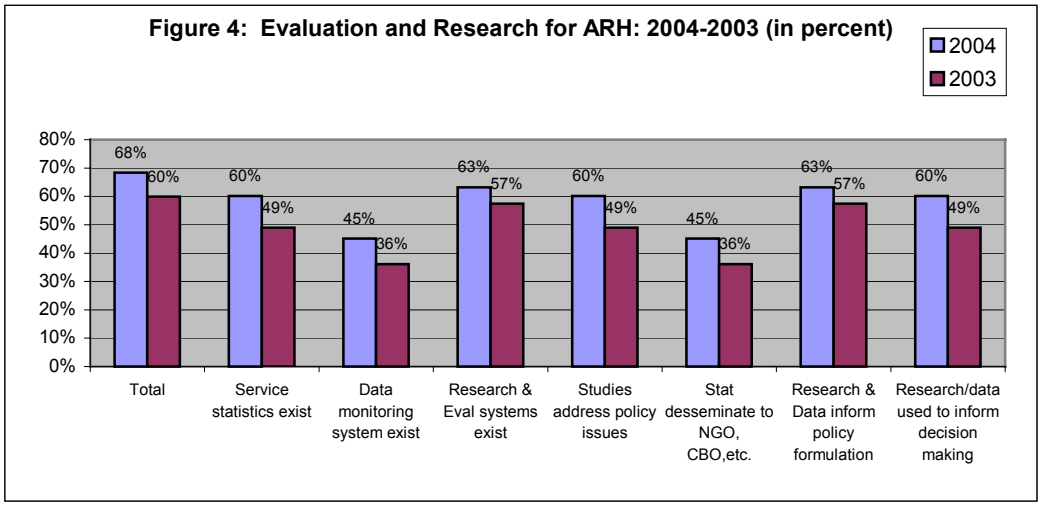
Policy Formulation (66% in 2003 and 77 % in 2004)

Policy formulation was the second highest ranked category at 77 percent of the maximum, improving 11 percentage points between 2003 and 2004. Figure 3 shows that there were significant improvements in all aspects of this component. The scores ranged from a high of 88 percent for policy support by government of antenatal care for pregnant adolescents to a low of 69 percent for the incorporation of male ARH in youth policy. Seven of the fifteen items received scores of 80 percent and above. These items were, policy supporting FLE/IEC efforts (85%), policy supporting STI treatment (84%), program goals (84%), the involvement of NGOs and community leaders in policy dialogue and formulation (82%), policy supporting FP (80%) and the existence of a national HIV/AIDS policy (81%). Seven of the items had scores ranging between 74 and 78 percent, while only one fell below 70 percent.



Evaluation and Research (60 % in 2003 and 68% in 2004)

Evaluation and research was the component with the third highest score (68%) for the Expanded ARH PES 2004.

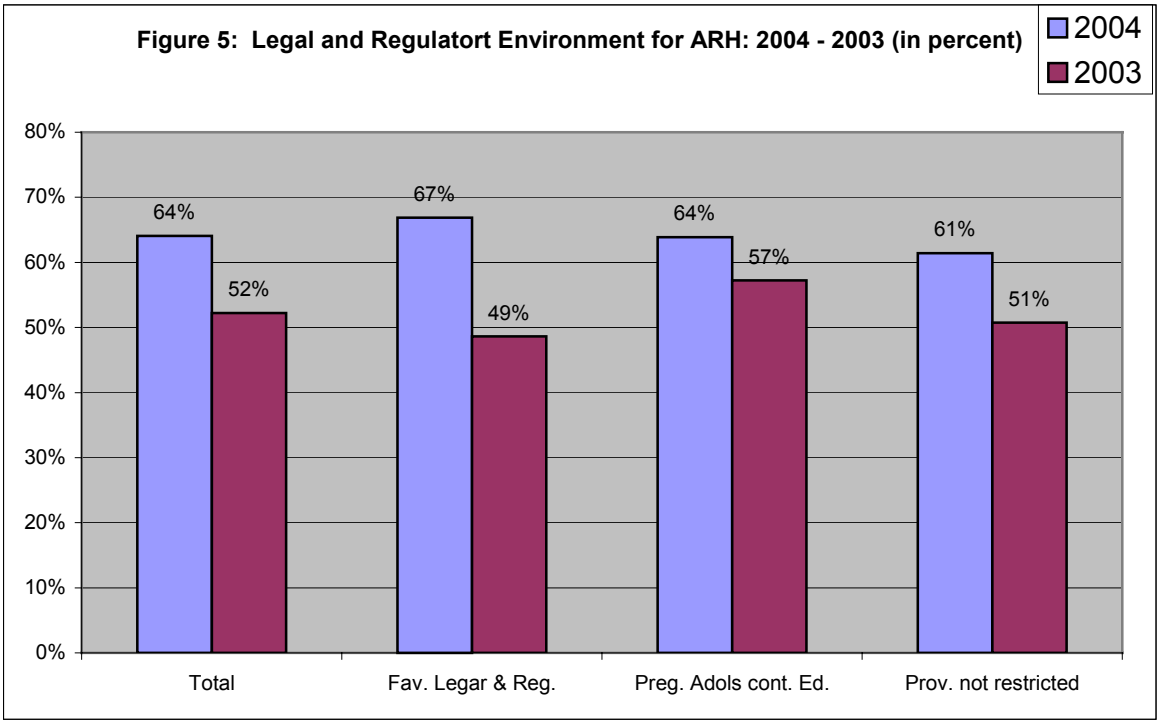


The overall score in 2004 (68 percent) has 8 percentage points above that for 2003 (60 percent). Figure 4 shows that respondents were of the view that service statistics do exist and function adequately, that studies are undertaken to address leading policy issues and that research and service data are used to inform decision-making. Each of these items showed an 11-percentage point increase over 2003. It appears, however, that respondents were not convinced that systems are in place to monitor secondary data sources for the benefit of policy guidelines, and that

statistics are not distributed effective to NGO's, CBOs and private sector. Both items had a score of 45 percent, which is the lowest score in this category.

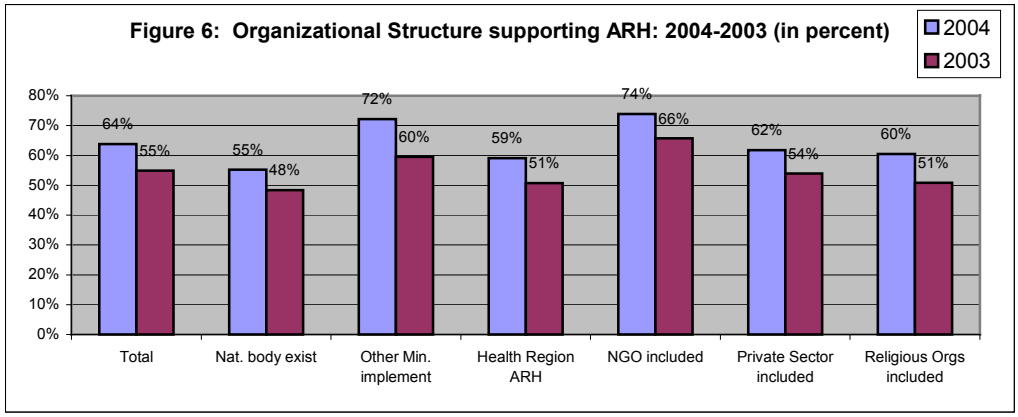
Legal/Regulatory Environment (52% in 2003 and 64% in 2004)

The legal and regulatory environment was one of two components ranking fourth in the Expanded ARH PES. At 64 percent in 2004 compared with 52 percent for 2003, this component recorded a 12-percentage point increase – the largest increase of all the seven components in the PES score. Figure 5 shows that respondents were of the view that a favourable legal and regulatory climate existed to ensure that adequate services for FP were provided that pregnant adolescent could continue their education in 2003/2004.



Organizational Structure (55% in 2003 and 64% in 2004)

Organizational structure was also ranked fourth in the Expanded ARH PES, moving from 55 percent in 2003 to 64 percent in 2004, a 9-percentage point increase as shown in Figure 6. All the items in this category registered an increase. The perception that NGOs are formally included in policy deliberations (74%) and that government ministries other than the Ministry of Health are mandated to help with program implementation (72%) contributed significantly to the increase. Respondents perceived, however, that a national coordinating body is needed to engage various ministries to assist with appropriate services.



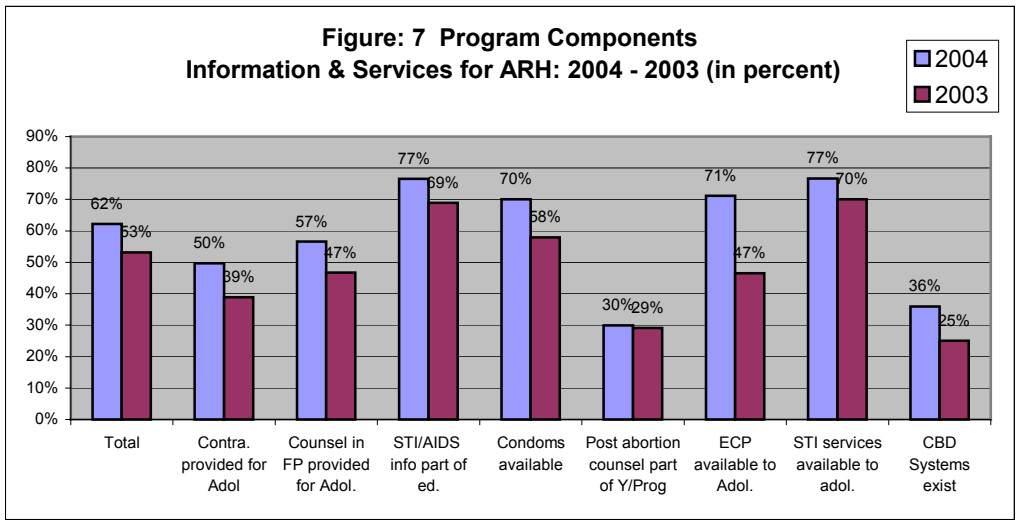
Respondents' perception of a mechanism existing at the regional level to coordinate planning, resource allocation, and implementation of ARH activities contributed to the increase in the score for organization. Improvements in the inclusion of NGOs and the private sector in policy deliberations and multisectoral implementation of the program also contributed to the increase in score. Respondents further believed that there is a need for a national coordinating body that will engage various ministries to assist with appropriate services for young people.

Program Components (53% in 2003 and 62% in 2004)

The items in the program components category have been broken down into five subcategories: information and services, training and service delivery, health and family life education, adequate targeting of vulnerable groups, and NGO participation. There was a 9-percentage point increase for the program components category due primarily to overall improvements in each of the five sub-categories.

Information and services

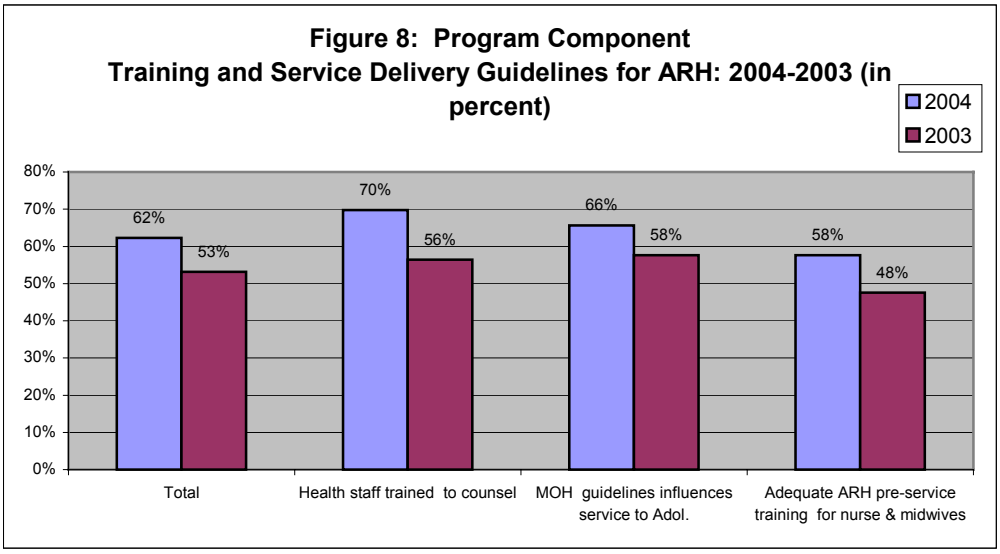
Of the eight items in this category, four registered scores of above 70 percent. Respondents were of the view that STI/AIDS information is an integral part of the education effort (77%) and that STI services are available to adolescents (77%). They also felt that ECP is available to adolescents (71%) and that condoms are easily available to youth through channels that youth have access to (70%).



Note: The columns reflecting the total score are for all program components combined.

They appear, however, not to be convinced that post abortion counselling is an integral part of the youth program, or that contraceptives are being made available through youth distributors via a community based distribution system. The feedback from most respondents was that STI/HIV services (including condoms) were more readily available to adolescents than as contraceptives. Details of the Information and Services program components are presented in Figure 7.

Training and services delivery

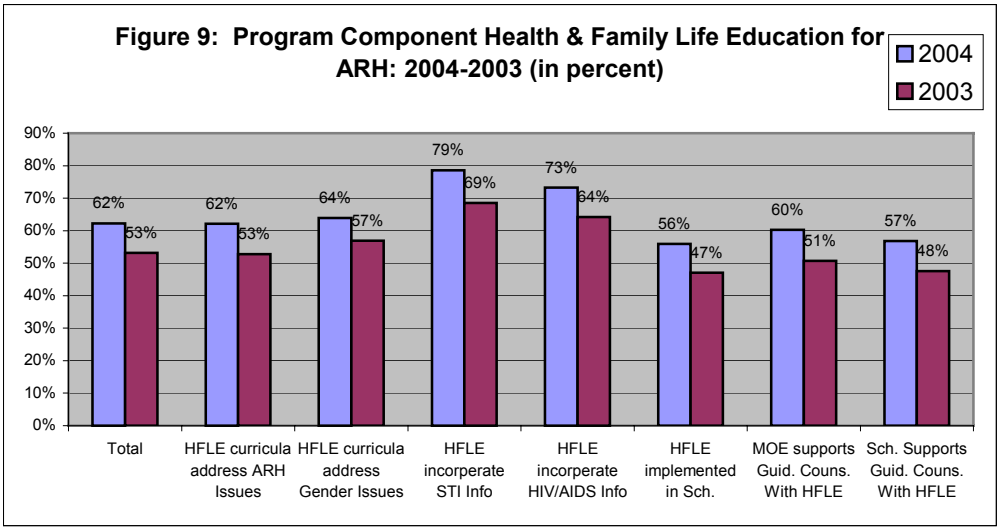


Note: The columns reflecting the total score are for all program components combined.

The three items included in training and service delivery guidelines category of the program component showed improvement in 2004 when compared with 2003. (See Figure 8) Respondents felt that providers were trained to provide RH services but more could to be done to improve pre-service training for nurses and midwives working with adolescents.

Health and Family Life Education

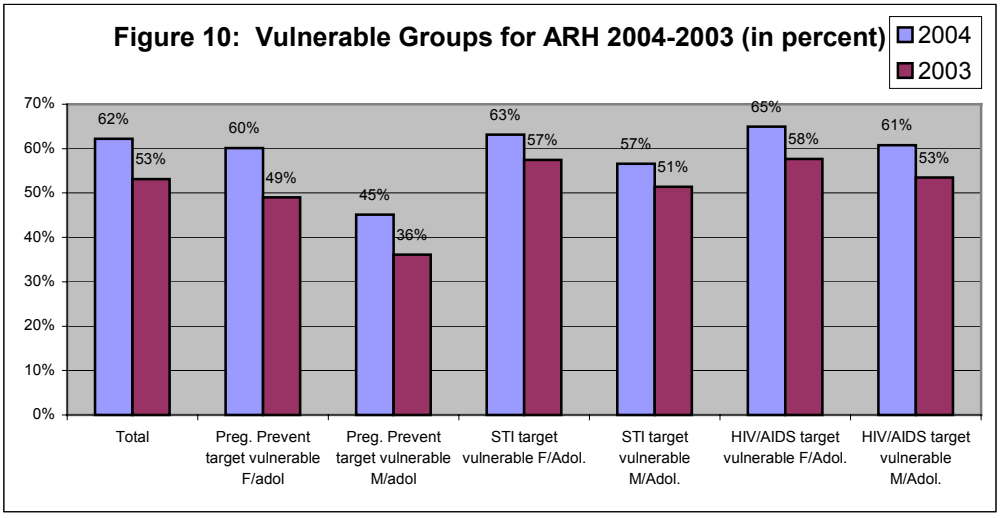
Several items are combined to create the HFLE Program Component. Scores for the individual items are presented in Figure 9. The items addressing the incorporation of STI (79%) and HIV/AIDS (73%) information into the HFLE curricula received the highest scores in this category. The responses to ARH and gender issues along with the support that the guidance counsellors get from the Ministry of Education (MOE) were fair – scores ranged between 60 and 64 percent.



Note: The columns reflecting the total score are for all program components combined.

It is also perceived that HFLE is not being effectively implemented in schools (56%) and that the guidance counsellors are not receiving adequate support from the school administration (57%).

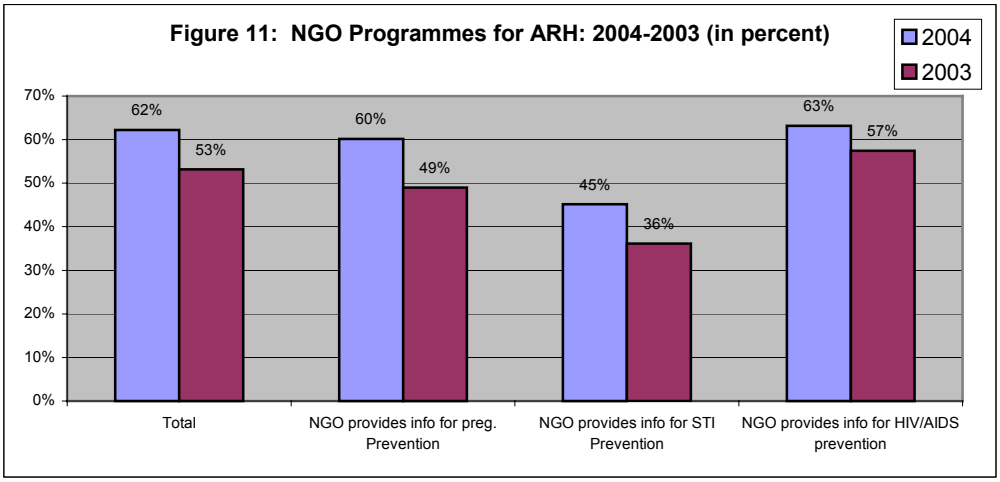
Vulnerable Groups



Note: The columns reflecting the total score are for all program components combined.

This category "Vulnerable Groups" as represented in Figure 10, had six items. All items showed improvement in 2004 over 2003. The overall scores, however, indicate that more needs to be done to address reproductive health needs of groups, especially male adolescents.

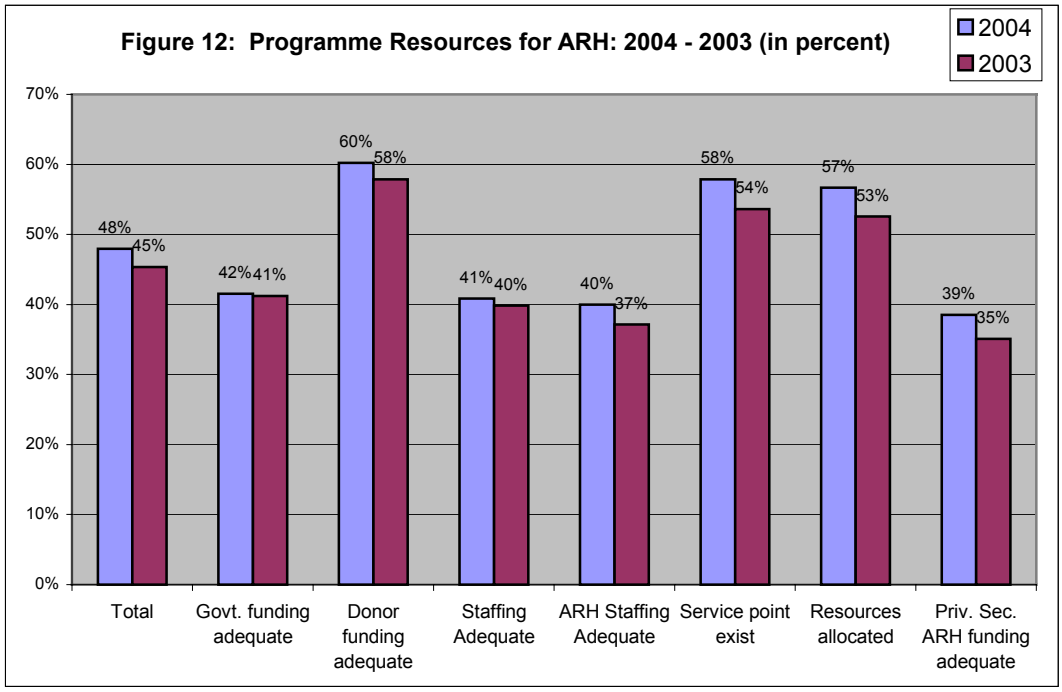
NGO Programs



Note: The columns reflecting the total score are for all program components combined.

Figure 11 shows scores for items in the NGO's Program category. The items indicate that in the three areas investigated, NGO's score highest on the provision of information for HIV/AIDS (63%) and pregnancy prevention (60%). They score much lower (45%) in the area of provision of information on STI.

Program Resources (45% in 2003 and 48% in 2004)



This component ranked sixth in the Expanded ARH PES for 2004 with a score of 48 percent. This is a marginal increase of 3 percentage points over the score of 2003. Scores indicate that donor support is perceived to be adequate (60%) and that resources are allocated to ARH. However the level of government funding for ARH (42%) funding for ARH from the private sector (39%) and staffing, including ARH staffing, are less adequate (41% and 40% respectively).

Comparing Components

The Expanded ARH PES for 2004 has seen an increase in all the components when compared with 2003. There was an overall increase of 8.8 percentage points, moving from 57.2 percent of the maximum of 100 percent in 2003 to 65.9 percent of the maximum in 2004. Table 2 will show a more detailed analysis of the individual items in the seven components. The table shows items, which received a score of 65 percent or higher and those that received scores of 50 percent or lower. Political Support for ARH, Policy Formulation and Programs had the largest number of items scoring 65 percent and above. In contrast Program and Resources had and included, the largest number of items scoring 50 percent or lower.

Table 2 shows the items within the seven components that received scores of 65 percent or higher and those that received 50 percent or lower.

Table 2. Items with High (65% or above) and Low (50% or lower) Scores in the Expanded ARH PES, by Component

Items with scores of 65% or higher	Items with scores of 50% or lower
Political Support for ARH (10 out of 13 items) Government support for FP Government supports HIV/AIDS Public support FP Public supports HIV/AIDS Media permitted Political parties support HIV/AIDS Recognition of teen pregnancy as a problem by top planning bureaus Recognition of HIV/AIDS as a problem by top planning bureaus Religious organizations support HIV/AIDS	**Political Support for ARH** (0 out of 13 items)
Policy Formulation (15 out of 17 items) Youth policy exists ARH policy exist HIV/AIDS policy exists Program goals exist Strategies exist Male ARH issues incorporated Other ministries are involved in policy development Civil society involved Religious organization involved Policy supports HFLE/IEC programs Policy support FP Policy supports ANC programs Policy supports STI programs Policy supports pregnant students finishing school Policy supports HIV students finishing school	**Policy Formulation** (0 out of 17 items)
Evaluation and research (0 of 7 items)	**Evaluation and research** (2 of 7 items) Data monitoring system exist Statistics are disseminated to NGOs, CBOs, etc.

Organizational structure (2 of 6 items) Other ministries help in program implementation NGOs included in policy deliberations	**Organizational structure** (0 of 6 items)
Legal and regulatory environment (1 of 3 items) Favourable legal and regulatory climate	**Legal and regulatory environment** (0 of 3 items)
Programs (9 of 27 items) STI/HIV/AIDS information is part of education efforts Condoms available ECP is available to adolescents STI services available to adolescents Health staff trained to counsel MOH guidelines influences service to adolescents HFLE incorporates STI information HFLE incorporates HIV/AIDS information HIV/AIDS target vulnerable female adolescents	**Programs** (5 of 27 items) Contraceptives are provided to adolescents Post abortion counseling is part of youth programs CBD systems exist Pregnancy prevention is targeted to vulnerable groups of young males NGOs provide information for STI prevention
Resources (0 of 7 items)	**Resources** (4 of 7 items) Government funding is adequate Staffing for service provision is adequate ARH staffing is adequate Private sector ARH funding is adequate

The policy formulation component was the only category in the Expanded ARH PES 2004 to have all its items scoring 65 percent or higher. Political support was next with fourteen of the fifteen items demonstrating a similar trend. One-third of the Programs component also had scores of 65 percent or higher. These were the areas which seemed to have the greatest level of improvement for the Expanded ARH PES in 2004. Some respondents also stated that "they have seen some level of improvement in the policy environment especially with the development of guidelines for health providers. Implementation has started to gather momentum, but greater commitment and rollout of strategies is required."

The legal and regulatory climate has also shown significant improvement. Not only has there be improvement for adolescents receiving family planning services, the provision of services by health care providers is now backed by the guideline on access to contraceptives to minors under 16 years of age. The presence of the policy should encourage a friendlier atmosphere as adolescents access RH services.

The program component has also shown improvements. Condoms are more readily available to Adolescents and the emergency contraceptive pill (Postinor) can now be obtained without a prescription. More health providers are accessing counselling skills and school based HFLE program and curricula. The HFLE programs are incorporating more STI/HIV/AIDS information in the schools. However one respondent thinks, "guidance counsellors in school must be motivated to carry out sustained HFLE programs, as their role is a vital one, due to the lack of

parental guidance in most cases." Programs to address vulnerable males especially related to pregnancy prevention are still lacking. One respondent noted that "the disparity between female- and male-specific services still exist and nee to be lessened." Another respondent suggested that very little is done in relation to disabled youth and adolescents with same sex orientation. The feeling is that current HFLE programs are geared towards reflecting "popular religious view."

The component of weakest perceived improvement was in the area of resources (with a 3 percentage point increase in 2004 over 2003). In addressing the need for more resources, a respondent states that "there is need for additional resources, financial, human and material for the ARH programs to be effective especially in the area of family planning."

IV. Conclusion

The Expanded ARH PES is not a perfect instrument for measuring the degree to which the policy environment is supportive of effective reproductive health policies and programs for adolescents. However, it does provide a useful measure for evaluating the changing status of the policy environment. The Expanded ARH PES reflects the initiatives that have been undertaken in the past few years to improve ARH in Jamaica. The government and donors have recognized the need among adolescents for reproductive health information and services. This is evident in the:

1. MOH's *Strategic Framework for Reproductive Health 2000–2005*, where adolescents are noted as a primary target group for reproductive health services (MOH, 2000).
2. Donor funding has increasingly been targeted to ARH activities.
3. The USAID-funded project, Youth.now, has been implemented in a number of parishes in Jamaica.
4. The UNFPA-European Commission program supporting RH programs for persons with disabilities, including adolescents, men and pregnant women.
5. Two working groups—one co-chaired by the MOH and the Planning Institute of Jamaica (PIOJ) and another of Parliamentarians— are addressing policy issues related to ARH.
6. The 1999 *Jamaica Family Planning Service Delivery Guidelines* (MOH and NFPB, 1999) includes a chapter on serving adolescents.
7. The new *Policy Guidelines for Health Professionals regarding Contraceptives for Persons under 16 Years old*.
8. National Policy for HIV/AIDS Management in schools
9. The development and approval of the National Youth Policy spearheaded by the National Centre for Youth Development.

This latest study (2004) of the ARH policy environment for effective policies and programs for adolescent reproductive health indicates that, in the opinion of key stakeholders, the policy environment changed in significant ways between 2003 and 2004. The largest positive change in that time period is reported in the situation with laws and regulations (Legal and Regulatory - 12.0%), followed by Policy Formulation (11%). Notwithstanding these positive changes, there is clear need for improvement in the resources available for ARH and in ARH evaluation and research.

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Appendix A. List of Participants

1. Dr. Alfred Brathwaite, STD Technical Consultant, Epidemiology Unit, Ministry of Health
2. Dr. Karen Lewis-Bell, Director, Family Health Division, Ministry of Health
3. Dr. Tina Hilton-Kong, Medical Officer for Health, Kingston & St. Andrew Public Health Department, Ministry of Health
4. Dr. Elizabeth Ward, Ministry of Health

5. Dr. Yitades Gebre, SMO HIV/STI Prevention and Control Project, Ministry of Health
6. Dr. Michelle Harris, RTD, SERHA
7. Dr. Kyaw Tint, Medical Officer (Health) Westmoreland
8. Mr. Verlie James – Parish Manager Westmoreland
9. Dr. Sheila Campbell Forrester, RTD, Ministry of Health, WRHA
10. Dr. Beverley Wright MO (Health), Manchester
11. Dr. Sonia Copeland, MO (Health) Clarendon
12. Mrs. Ellen Radlein, Director, Projects & Research, National Family Planning Board
13. Mrs. Eugenia McFarquahar, Health Consultant
14. Dr. Olivia McDonald, National Family Planning Board
15. Mrs. Beryl Chevannes, Health Consultant
16. Ms. Pansy Hamilton, Fertility Management and Research Unit, UWHI
17. Dr. John Hall, President Medical Association of Jamaica
18. Mrs. Iris Wilson, President Nurses Association of Jamaica
19. Mrs. Sarah Newland-Martin, Executive Director, Young Men Christian Association
20. Rev. Webster Edwards, Director, Operation Friendship
21. Mrs. Beryl Weir, National Director, The Women's Centre of Jamaica Foundation
22. Mrs. Zoe Simpson, Women's Center of Jamaica Foundation
23. Mrs. Sonita Abrahms, Addition Alert
24. Dr. Peter Swaby, Hope Worldwide Jamaica
25. Dr. Faye Whitbourne, ACROSTRAD
26. Ms. Ann-Marie Bonner, Policy Analysis, Office of the Prime Minister
27. Mr. Ian McKnight/Dr. Robert Carr, Executive Director, Jamaica AIDS Support
28. Mrs. Peggy Scott, Jamaican Family Planning Association, St. Ann
29. Mrs. Burrell, Rural Family Support Organization, Clarendon
30. Mrs. Jennifer Knight-Johnson, Project Specialist/CTD, USAID
31. Ms. Penny Campbell, Adolescent HIV/AIDS Officer, UNICEF
32. Ms. Verity Rushton, UNICEF
33. Mr. Dervan Patrick, Health Specialist, UNFPA
34. Mrs. Claudette Pious, Project Director, Children First, St. Catherine
35. Dr. Michael Coombs Regional Technical Director, Southern Regional Health Authority
36. Dr. Heather Reid-Jones MO (Health) St. Catherine
37. Mr. Layne Robinson, National Centre for Youth Development (in Ministry of Education)

The following persons were also invited to participate but were unavailable, declined due to pressure of work, or alternatively, they passed their questionnaires to persons who were already in receipt of questionnaires:

38. Dr. Blossom Anglin-Brown, Director, University Health Services, UWI, Mona
39. Dr. Deloris Brissett, Deputy Chief Education Officer (Acting), Ministry of Education
40. G. Omphroy-Spencer, Victoria Jubilee Hospital
41. Dr. J. Fredericks, OB/GYN, University Hospital
42. Dr. Carol Rattray, OB/GYN, University Hospital

43. Dr. Harris Fletcher, Grabham Society, University Hospital
44. Mrs. Grace Allen-Young, Permanent Secretary, MOH
45. Professor Hugh Wynter, Fertility Management and Research Unit, UWHI
46. Mrs. Lois Owen, Pharmacists Council
47. Mr. Robert Bryan Executive Director, Social Development Commission (SDC)
48. Dr. T. Alexander, MO (H), Cornwall Regional Hospital
49. Dr. Derrick Ledford MO (H), St. Elizabeth Health Department
50. Dr. Douglas McDonald, Senior Medical Officer, Victoria Jubilee Hospital
51. Ms. Lois Hue, Director of Youth Services, Red Cross, St. Catherine
52. Dr. Jeremy Knight – MO (Health), Portland
53. Nurse Rose Scringer, MOH
54. Dr. Manuel Pena, PAHO
55. Dr. Michele Roofe RTD, NERHA
56. Mrs. Claire Spence, USAID
57. Mr. Joseph Robinson – Executive Director, ASHE
58. Mrs. Perlene Allen-Mitcelle, Regional Program Development Officer, NERHA
59. Dr. Peter Weller, Psychologist, University Health Centre

Appendix B. 2004 Expanded ARH Policy Environment Score Questionnaire

Respondent Guide

The following comments are intended to assist you in responding to the items on the questionnaire.

1. The last Expanded ARH PES was done in 2002. ***"Status now"*** speaks to 2004 and ***"status one year ago"*** is 2003
2. Scoring - All the items are scored on a 0 – 4 scale with 4 being strongest and 0 being weakest.
3. This survey is focusing only on the adolescents.

Political Support

4. ***"Planning bureaus"*** item 11, speaks to bodies such as PIOJ and the MOH Planning Unit.

Program Components

5. ***"Community-Based Distribution (CBD) systems"*** (item 8) speaks to those communities where individual members of the community provide FP services for short periods of time. These individuals also refer to the local health centers for follow-up service.
6. HFLE curricula speak to the MOE curricula introduced into the Primary and Secondary schools.
7. "Vulnerable groups" (items 23-28) – youth at risk. E.g. youth living on the street, those unemployed, dropped out of school, handicap/persons living with disabilities.

Instructions.

Rate each item twice – once to reflect the current status (2004) and once to indicate the status a year ago (2003). The items are scored on a 0-4 scale with 0 being weak and 4 being strong. Please place the appropriate score in the box beside the corresponding item.

(Scoring: 0=weak; 4 = strong)		
I. POLITICAL SUPPORT	**Status Now 2004**	**Status 1 Year Ago**
1. High-level national government support exists for effective policies and programs.		
2. High-level national government support exists for effective policies and programs to provide family planning to unmarried adolescents.		
3. High-level national government support exists for effective policies and programs for prevention of HIV/AIDS among adolescents.		
4. Public opinion supports effective policies and programs.		
5. Public opinion supports effective policies and programs to provide family planning to unmarried adolescents.		
6. Public opinion supports effective policies and programs for prevention of HIV/AIDS among adolescents.		
7. Media campaigns are permitted.		
8. Political parties support effective policies and programs.		
9. The problem of pregnancy among adolescents is recognized by top planning bureaus.		
10. The problem of HIV/AIDS among adolescents is recognized by top planning bureaus.		
11. The problem is recognized by top planning bureaus.		
12. Major religious organizations support effective policies and programs to provide family planning to unmarried adolescents.		
13. Major religious organizations support effective policies and programs for prevention of HIV/AIDS among adolescents.		

II. POLICY FORMULATION	**Status Now 2004**	**Status 1 Year Ago**
1. A favorable national policy exists.		
2. A favorable national youth policy exists.		
3. A favorable national ARH policy exists.		
4. A favorable national HIV/AIDS policy exists that includes adolescents.		
5. Formal program goals exist.		
6. Specific and realistic strategies to meet goals exist.		
7. Youth policies incorporate male adolescent reproductive health issues.		
8. Youth policies address male adolescent reproductive health.		
9. Ministries other than Health are involved in policy formulation.		
10. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.		
11. Policy dialogue and formulation involves religious organizations		
12. Government policy supports family life education and other IEC efforts for youth		
13. *Government/ national policy supports provision of contraception for adolescents.*		
14. *Government/national policy supports provision of antenatal care for pregnant adolescents*		
15. Government/national policy supports provision of STI treatment for adolescents		
16. *Government/ national policy supports pregnant teenagers continuing their education*		
17. *Government/national policy supports students with HIV continuing in school*		

III. ORGANIZATIONAL STRUCTURE	**Status Now 2004**	**Status 1 Year Ago**
1. A national coordinating body exists that engages various ministries to assist with appropriate services. (If none, enter zero.)		
2. Ministries other than Health are mandated to help with program implementation.		
3. A mechanism exists at the health region level to coordinate planning, resource allocation and implementation of ARH activities.		
4. NGOs are formally included in policy deliberations.		
5. The private sector is formally included in policy deliberations.		
6. Religious organizations are formally included in policy deliberations.		

IV. LEGAL AND REGULATORY ENVIRONMENT	Status Now 2004	Status 1 Year Ago
1. There is a favorable legal and regulatory climate for ensuring that unmarried adolescents may receive services for family planning.		
2. Pregnant adolescents are allowed to continue with their education.		
3. Providers are free from unnecessary legal and regulatory restrictions (i.e., services available to adults are available to adolescents as well).		

V. PROGRAM RESOURCES	Status Now 2004	Status 1 Year Ago
1. Funding from government sources is generally adequate.		
2. Funding from donor sources is generally adequate.		
3. Staffing for service provision is generally adequate.		
4. Staffing for ARH service provision is generally adequate.		
5. Enough service points and providers exist for reasonable access by most clients.		
6. Resources are allocated by explicit priority guidelines.		
7. Funding/other support for ARH from private sector is generally adequate.		

VI. PROGRAM COMPONENTS	Status Now 2004	Status 1 Year Ago
1. Contraceptives are provided for single adolescents in the usual service delivery points, as well as in schools, youth centers and other places where youth are found.		
2. Counselling services in family planning for single adolescents are offered not only in the usual service delivery points, but also elsewhere, such as in schools, youth centers, or other places where youth are found.		
3. STD/AIDS information is an integral part of educational efforts.		
4. Condoms are easily available to youth through channels that youth have access to, e.g. pharmacies, clinics, vendors.		
5. Post-abortion counseling is an integral part of the youth program.		
6. Emergency contraceptive protection (ECP) is available to unmarried adolescents.		
7. STI services are available to unmarried adolescents		
8. Health staffs are trained to counsel youth in sexuality and reproductive health matters.		

VI. PROGRAM COMPONENTS (cont.)	Status Now 2004	Status 1 Year Ago
9. Community-based distribution (CBD) systems exist and employ youth (male and female) distributors. (If no CBD system exists, enter zero.)		
10. HFLE curricula are appropriate to address ARH issues in the country		
11. HFLE curricula take gender issues into account.		
12. HFLE curricula incorporate STI information		
13. HFLE curricula incorporate HIV/AIDS information		
14. HFLE is being effectively implemented in schools		
15. Guidance counselors receive support from the MOE to teach HFLE		
16. Guidance counselors receive support from school administrators to teach HFLE		
17. MOH's service delivery guidelines for serving minors influences service delivery for adolescents		
18. Pre service training in ARH for nurses and midwives is adequate.		
19. Pregnancy prevention efforts are adequately targeted to vulnerable groups of female adolescents.		
20. Pregnancy prevention efforts are adequately targeted to vulnerable groups of male adolescents.		
21. STI control efforts are adequately targeted to vulnerable groups of female adolescents.		
22. STI control efforts are adequately targeted to vulnerable groups of male adolescents.		
23. HIV/AIDS control efforts are adequately targeted to vulnerable groups of female adolescents.		
24. HIV/AIDS control efforts are adequately targeted to vulnerable groups of male adolescents.		
25. NGOs participate in the provision of information for pregnancy prevention.		
26. NGOs participate in the provision of information for STI prevention.		
27. NGOs participate in the provision of information for HIV/AIDS prevention.		

Comments: _____

VII. EVALUATION AND RESEARCH	Status Now 2004	Status 1 Year Ago
1. A regular system of service statistics exists and functions adequately.		
2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.) for the benefit of policy guidance.		
3. A system exists to bring evaluation and research results to management's attention.		
4. Special studies are undertaken to address leading policy issues.		
5. *Service statistics are effectively disseminated to NGO, CBO and private sector*		
6. *Research and service data/information are used to inform policy formulation*		
7. *Research and service data/information are used to inform decision making*		

Comments: